UNITED NATIONS

ST

Secretariat

ST/IC/1996/33
24 May 1996

INFORMATION CIRCULAR

To: Members of the staff at Headquarters

From: The Controller

Subject: RENEWAL OF THE HEADQUARTERS MEDICAL AND DENTAL INSURANCE PLANS EFFECTIVE 1 JULY 1996, AND ANNUAL ENROLMENT CAMPAIGN, 3-7 JUNE 1996*

General

1. The purpose of the present circular, which supersedes information circular ST/IC/1995/31, dated 25 May 1995, is to announce:

(a) The 1996 medical and dental insurance enrolment campaign;

(b) Changes in the premium and contribution rates that will come into effect on 1 July 1996 (see p. 2);

(c) The introduction, with effect from 1 July 1996, of the Blue Cross BlueChoice PPO (preferred provider organization) plan. This plan is a similarly structured and expanded replacement for the WrapAround Plus plan, which Blue Cross is discontinuing in favour of BlueChoice (see annex II);

(d) Elimination of the mandatory second surgical opinion requirement under the Aetna Plan. A second surgical opinion will still be reimbursed; however, there will no longer be any financial penalty for failure to obtain a second surgical opinion.

Apart from the modifications referred to above, the only changes in the Headquarters plans for 1996/97 will be in the levels of the related premium and contribution rates.

2. Annexes I to VIII to the present circular set out plan outlines and benefit summaries. These annexes are listed in paragraph 23.

* Personnel Manual index No. 6170.

HEADQUARTERS MEDICAL AND DENTAL INSURANCE
SCHEDULE OF MONTHLY PREMIUMS a/ AND CONTRIBUTION RATES b/
(Effective 1 July 1996)

Type of coverage		Aetna	Blue Cross BlueChoice PPO	HIP/HMO	Kaiser/HMO	GHI Dental with medical plan	GHI Dental alone
Staff member only							
Premium rate	($)	319.34	216.29	181.98	183.43	23.14	23.14
Contribution rate	(%)	3.04	2.07	1.75	1.76	0.22	0.34
Staff member and one child							
Premium rate	($)	614.51	431.53	360.24	366.86	55.15	55.15
Contribution rate	(%)	5.14	3.66	3.00	3.08	0.43	0.65
Staff member and spouse							
Premium rate	($)	614.51	431.53	360.24	366.86	55.15	55.15
Contribution rate	(%)	5.14	3.66	3.00	3.08	0.43	0.65
Staff member and two or more eligible family members							
Premium rate	($)	775.05	626.55	531.51	495.27	115.59	115.59
Contribution rate	(%)	5.78	4.70	4.01	3.66	0.85	1.27

a/ The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

b/ "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

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Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 3 to 7 June 1996 at the offices of the Insurance Section of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. STAFF MEMBERS AT HEADQUARTERS MUST COME IN PERSON TO THE INSURANCE SECTION OFFICE TO COMPLETE THE APPLICATION FORM AND OTHER FORMS AS NECESSARY. The staff of the Insurance Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 3, 4 and 5 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. **Staff members are reminded that, except as provided in paragraphs 12 and 13 below, this will be the ONLY opportunity until June 1997 to enrol in the United Nations medical and dental insurance plans.** This is also an opportunity to review current medical insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans, as may be necessary or desirable. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign are:

(a) Aetna Hospitalization/Major Medical (Aetna);

(b) Blue Cross BlueChoice PPO (BlueChoice);

(c) Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO);

(d) Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO);

(e) Group Health Incorporated Dental Plan (GHI).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1996. **A change in enrolment between the Aetna and Blue Cross BlueChoice plans will oblige the participant to meet the annual deductible in the new plan.**

Eligibility for enrolment

7. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under Staff

Rule 206.4. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

8. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance Section. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

9. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not engaged in full-time employment; disabled children may be eligible for continued coverage after age 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

10. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

11. **In the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.** It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance (ASHI) benefits following separation from service.

Enrolment between annual campaigns

12. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans ONLY if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters from another duty station;

(d) Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 15 below);

(e) Upon assignment to a mission, under certain conditions (see para. 16 below); and/or

(f) Upon marriage, birth or legal adoption of a child for coverage of the related family member.

Staff members who can demonstrate that they were on mission or annual or sick leave for the entire duration of the annual campaign may enrol within 31 days of their return to Headquarters.

13. In all cases, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance Section
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

14. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance Section and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

15. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) Insurance coverage maintained during special leave without pay. If the staff member decides to retain coverage during the period of special leave without pay, the Insurance Section MUST be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) Insurance dropped while on special leave without pay. Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) Re-enrolment upon return to duty following special leave without pay. Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done within 31 DAYS OF RETURN TO DUTY. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next annual enrolment campaign in the month of June.

Special insurance provisions in connection with the 1996 Early Separation Programme are set out in administrative instruction ST/AI/414/Add.1.

Staff members assigned on mission

16. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are NOT enrolled in any United Nations health insurance plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in a health insurance plan in these circumstances must be completed PRIOR to the departure of the staff member on mission assignment;

(b) Staff members assigned to a mission who are enrolled in either HIP or Kaiser, two plans which do not offer full services at locations away from

Headquarters, may switch to either Aetna or BlueChoice. These two plans provide benefits on a worldwide basis, although in the case of BlueChoice, there are no participating physicians outside the Headquarters area. Enrolment in the Aetna or BlueChoice plans under this provision must be completed PRIOR to the departure of the staff member on mission assignment;

(c) Staff members who, at the time of commencement of the mission assignment, do not have GHI Dental coverage but who are already enrolled, together with eligible family members, in Aetna or BlueChoice, may enrol themselves and family members covered under their medical insurance plan in the dental plan. Such enrolment must be completed PRIOR to the departure of the staff member on mission assignment;

(d) Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs (a) to (c) above forego the right to make any further change during the annual enrolment campaign taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment campaign of the following year;

(e) Staff members who are already enrolled in Aetna or BlueChoice at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

(f) Staff members who will be on mission assignment for six months or more AND WHO WILL NOT HAVE ELIGIBLE COVERED FAMILY MEMBERS RESIDING IN THE UNITED STATES for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance Section, room S-2765;

(g) Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph (f) above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance Section within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

IN ALL CASES, STAFF MEMBERS GOING ON MISSION ASSIGNMENT WHO WISH TO ENROL IN A HEALTH INSURANCE PLAN OR CHANGE THEIR PRESENT COVERAGE, AS PROVIDED ABOVE, MUST PRESENT EVIDENCE TO THE INSURANCE SECTION OF THE MISSION ASSIGNMENT AND ITS DURATION.

Cessation of coverage of family members

17. The Insurance Section should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, e.g., a spouse upon divorce or a child reaching the end of the calendar year in which the age of 25 years is attained, marrying or taking up full-time employment. The responsibility for initiating the resulting change in coverage (e.g. from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") RESTS WITH THE STAFF MEMBER. Staff members who wish to discontinue coverage of a family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. Such removals of family members from coverage should be communicated to the Insurance Section directly. It is in the interest of staff members to notify the Insurance Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance Section.

After-service health insurance

18. Staff members are reminded that, among the eligibility requirements for ASHI coverage, the ASHI applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of 5 years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized ASHI participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the ASHI staff member at the time of separation are eligible for continued coverage under the programme. After-service participants are reminded that the restriction set out in paragraph 4 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. Full details on the eligibility requirements and administrative procedures relating to ASHI coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

19. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all plans currently offered. The conversion privilege, which is part of the United Nations group contracts with the respective insurance companies, means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. THE CONVERSION PRIVILEGE, HOWEVER, DOES NOT MEAN THAT THE SAME INSURANCE PREMIUM RATES OR SCHEDULE OF BENEFITS IN EFFECT FOR THE UNITED NATIONS GROUP POLICY WILL BE OFFERED IN RESPECT OF INDIVIDUAL INSURANCE CONTRACTS. It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the

United States as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised WITHIN 31 DAYS OF THE DATE OF SEPARATION. Details concerning conversion to individual policies under Aetna and Blue Cross BlueChoice may be obtained from the Insurance Section, room S-2765. Details concerning conversion to individual policies under HIP, Kaiser and GHI Dental should be obtained from those companies directly.

Where to address claims and benefit inquiries

20. Although the staff of the Insurance Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex VIII to the present circular.

21. Staff members are reminded that the plan descriptions set out in annexes I to VI constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. However, in the event of a claim dispute with any of the insurance carriers concerned, the resolution of such dispute will be guided by the terms and conditions of the respective policy contract and the final decision will rest with the insurance carrier concerned, not with the United Nations. The contracts with the insurance carriers are available for review by subscribers, as may be necessary, by appointment at the offices of the Insurance Section, room S-2765.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

22. The United Nations policies with Aetna, Blue Cross and GHI are "experience-rated". This means that the premium cost each year of the Aetna, BlueChoice and GHI Dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been relatively moderate, the premium increase in the subsequent year will be correspondingly moderate. The two health maintenance organization (HMO) plans, HIP and Kaiser, are "community-rated". This means the premium costs are based on the combined experience of all employers participating in these schemes, not just the United Nations, and are approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

23. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

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I.	Aetna Hospitalization/Major Medical Plan	11
II.	Blue Cross BlueChoice PPO	22
III.	HIP/HMO	30
IV.	Kaiser/HMO	33
V.	GHI Dental	36

In addition, information regarding the World Access (formerly Access America) emergency facility for Aetna and BlueChoice subscribers, a listing of participating Aetna and BlueChoice pharmacies as well as a listing of insurance carrier addresses and telephone numbers are set out in the following annexes:

VI.	World Access	42
VII.	Aetna and BlueChoice, participating pharmacies	43
VIII.	Insurance carrier addresses and telephone numbers for claims and benefit inquiries	44

Annex I

AETNA HOSPITALIZATION AND MAJOR MEDICAL PLAN

Plan outline

The Aetna Hospitalization/Major Medical (Aetna) insurance plan is a full-indemnity plan that offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing. Hospital costs for semi-private accommodation are covered in full for 365 days, after which, if the patient continues to remain in hospital, further expenses are covered under the major medical component of the Aetna plan. Expenses for surgical and medical treatment and prescription drugs are reimbursed at 80 per cent, after meeting an annual deductible of $125 per individual or $375 per family. Prescription drugs are also available with a lower deductible through the Aetna Discount Prescription Drug programme. When a participant has met the annual deductible and a further $1,000 in co-payment (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-payment requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan.

Premium

The monthly premium for the Aetna plan will increase by 8.7 per cent compared with present rates for the renewal period commencing 1 July 1996. The new premiums and percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Heretofore, reimbursement in respect of 16 surgical procedures performed on a non-emergency basis required a second surgical opinion, and failure to provide a second opinion resulted in a reduction of the reimbursement for the surgery by 50 per cent. **With effect from 1 July 1996, obtaining a second surgical opinion is no longer mandatory, and no penalty will be assessed by the insurer if a second opinion is not obtained.** However, the second surgical opinion, if desired, will continue to be reimbursed at normal rates.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 73
3541 Winchester Road
Allentown, PA 18195-0501

/...

The customer service number is (800) 858-5630. AS THE PLAN INCURS A SERVICE CHARGE FOR EACH CLAIM SUBMITTED, PARTICIPANTS ARE URGED NOT TO FILE CLAIMS WITH AETNA UNTIL ONE CLAIM OR A GROUP OF CLAIMS EQUALS OR EXCEEDS THE APPLICABLE ANNUAL DEDUCTIBLE.

Aetna plan benefits summary

Part I. Hospitalization benefits

Hospital expenses in any legally constituted hospital for the following:

A. In-patient care

Bed, board and general nursing care
Other hospital services
Pulmonary tuberculosis
Physical therapy and rehabilitation
Maternity care
Hospice care
Hemodialysis for kidney failure

B. Out-patient care

Emergency first aid or minor surgery
If treatment is not deemed to be an emergency, coverage will be under the major medical portion of the plan, subject to deductible and co-payment

Pre-surgical testing
Must be within seven days prior to the surgery in question and at the hospital in which the surgery will be performed for it to be covered under the hospitalization benefit

Home health care
Certain conditions apply to this benefit relating to the number of days home care commences following discharge from the hospital and the maximum number of home care visits allowable in a given year. For additional details, consult the Aetna claims office or the Insurance Section.

Hemodialysis for kidney failure

C. Three hundred and sixty-five (365) days of care at full cost of bed and board based on semi-private room accommodation. Confinement in a hospital beyond 365 days will be borne by the major medical component (see part II below)

D. Full cost of other hospital services while an in-patient, e.g., use of operating, cystoscopic and recovery room and equipment, X-ray examinations, laboratory and pathological examinations, prescribed drugs and medicine administered in hospital, etc.

E. Coverage for up to 210 days of in-patient hospice care in a certified hospice or hospital and home care and out-patient services provided by the hospice if the patient has been certified by his or her primary attending physician as having a life expectancy of six (6) months or less

F. Full cost of 30 out-patient visits per calendar year for emergency treatment as follows:

1. Emergency first aid during the first visit for treatment of an accidental injury within 72 hours following such injury; or

2. Emergency care during the first visit for treatment within 12 hours of the onset of sudden or serious illness; or

3. Minor surgery

G. Full cost of out-patient services for pre-surgical testing conducted in the same hospital where surgery is scheduled

H. Full cost of home care, subject to specific conditions

I. Full cost of 45 days of in-hospital physiotherapy and rehabilitation

J. Full cost of in-patient and out-patient services for hemodialysis

K. Full cost for a mammogram, regardless of age, for women with a past history or family history of breast cancer, upon the recommendation of a physician. In addition, with or without the recommendation of a physician, coverage will be provided for:

1. One baseline mammogram for women ages 35 to 39;

2. A mammogram every two years for women ages 40 to 49; and

3. An annual mammogram for women age 50 and older

To be covered in full under the above conditions, the mammogram must be performed in a hospital on either an in-patient or out-patient basis. Under the major medical component (part II below), Aetna will reimburse the cost of a mammogram not carried out in a hospital without any age or frequency limits. This benefit is subject to the normal deductible and co-payment provisions.

L. Skilled nursing facilities are covered when the treatment in the facility would otherwise be rendered by a hospital if no skilled nursing facility was available. Overseas coverage is approved if the facility is properly accredited and provided that the above-mentioned conditions are met. In reviewing any overseas facility, the focus is on whether the facility provides:

(a) Direct supervision by a doctor;
(b) Registered professional nurses on duty 24 hours a day;
(c) On-site physical therapists and other professionals.

Specifically, the skilled nursing benefit amounts to two days for every one day of covered hospitalization not utilized. The skilled nursing facility benefit does not provide coverage for custodial care, rest homes, spas and nursing homes where the services do not meet the above criteria.

Part II. Major medical benefits

Expenses for medically necessary services and supplies listed under sections A and B below will be reimbursed at 80 per cent after the application of a calendar-year deductible of $125 per person or $375 per family, provided that such expenses fall within the REASONABLE AND CUSTOMARY fee levels established by the insurer for the related medical service or procedure in the area of the doctor's place of business. In any calendar year, after an insured person's total unreimbursed expenses reach $1,000 (and after satisfying the deductible), covered expenses for that person will be reimbursed in full for the rest of that year.

A. Hospital expenses incurred after exceeding hospitalization coverage maxima listed in part I are covered by the Aetna major medical component. Covered expenses include charges for semi-private hospital room, board, general nursing care, X-ray and laboratory examination, etc.

B. Other covered medical expenses include:

1. The services of a legally qualified physician.

2. The services of a private-duty registered nurse (RN) other than a nurse who ordinarily resides in the staff member's home or who is a member of the staff member's family or his or her spouse's family. Private nursing services in a hospital are not generally considered necessary unless they are in lieu of intensive care or critical care unit nursing services. The circumstances under which private nursing charges are payable are very rare. If your physician recommends such treatment, please contact the Aetna claim office for guidance.

3. Drugs and medicines obtainable only on a prescription of a legally qualified physician.

4. Diagnostic laboratory and X-ray examinations.

5. X-ray, radium and radioactive isotope therapy.

6. Anaesthetics and oxygen.

7. Rental of durable medical or surgical equipment.

8. Artificial limbs and artificial eyes (eye examinations, eyeglasses and hearing aids are excluded).

9. Professional ambulance service when used to transport the individual from the place of injury resulting from an accident or where stricken by a disease to the first hospital where treatment is given. No other charges in connection with travel will be covered.

10. Spinal disorder treatment (chiropractic services) subject to a $1,000 calendar year reimbursement limit.

11. The cost of up to two blood tests per covered person per year for the HIV virus.

12. Coverage for the reasonable and customary charges for mammograms without any age or frequency limits once the annual deductible has been met.

C. Well-child care

1. Certain benefits to promote well-child care have been mandated under New York State insurance regulations. The essential feature of the well-child care benefit is that certain primary and preventive care services for covered dependants from birth up to age 19, as detailed below, will be covered at 100 per cent, not subject to deductible or co-payment.

2. The primary and preventive care services covered under this benefit provision are as follows:

Newborn child	One in-hospital examination at birth
Birth to age 1	Six visits in the first 12 months
Age 1 to age 2	Two visits in any 12-month period
Age 3 to age 6	One visit in any 12-month period
Age 7 to 19th birthday	One visit in any 24-month period

Covered services include a physical exam, developmental assessment, anticipatory guidance and laboratory tests ordered at the visit and performed either in the office or a laboratory. In addition, immunizations are covered as part of the well-child visit. Such immunizations will include at least the following: diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilius influenza type B and hepatitis B.

3. Not covered under this benefit and, therefore, subject to the normal deductible and co-payment, are:

(a) Services which are for diagnosis or treatment of a suspected or identified injury or disease;

(b) Services not performed by or under the supervision of a physician or a registered professional or licensed practical nurse;

(c) Medicines, drugs, appliances, equipment or supplies.

D. Hearing-aid and optical lens benefits

1. Reimbursements to be made by Aetna in regard to hearing-aid and optical lens claims will be subject to the normal deductible and co-payment requirements of these plans. In addition, a one-year waiting period will apply, which means that only subscribers and covered family members who have been enrolled in the plan for at least 12 months will be eligible to receive the benefit. A description of the hearing-aid and optical lens benefit is set out below.

2. The hearing-aid benefit is as follows:

(a) Covered expenses: The reasonable and customary charge for a hearing aid or aids provided that such aid or aids were purchased as a result of a written recommendation by a physician certified as an otolaryngologist. Covered hearing-aid expenses will include the reasonable and customary charge for the hearing-aid evaluation and audiometric examination performed by the otolaryngologist or state certified audiologist. The maximum covered expense per hearing aid recognized under this plan will be $600. The combined maximum covered expenses for all hearing-aid evaluations or audiometric examinations will be $100;

(b) Benefit: 80 per cent of covered hearing-aid expenses;

(c) Limitations: The number of hearing aids will be limited to one per ear per insured employee or covered dependant during any period of three consecutive years. No more than one hearing-aid evaluation and one audiometric examination will be covered during any consecutive three-year period.

Replacements are covered only if the hearing aid being replaced has been in use for at least three years and such replacement is made upon the written recommendation of a physician certified as an otolaryngologist.

3. Covered expenses do not include and no benefits are paid for:

(a) Charges for services or supplies which are covered in whole or in part under any other portion of the plan;

(b) Audiometric examinations by an audiologist that are not ordered by an otolaryngologist;

(c) Medical or surgical treatment;

(d) Drugs or other medication;

(e) Audiometric examinations, hearing-aid evaluation tests and hearing aids provided under any applicable Workmen's Compensation Law.

4. Coverage under the optical lens benefit is an addition to any benefits related to eye-care payable under the medical part of the Aetna plan:

(a) Covered expenses: The reasonable and customary charge for optical lenses with a maximum of $60 for any two lenses ($30 per lens);

(b) Benefit: 80 per cent of covered optical lenses;

(c) Limitation: The number of optical lenses will be limited to two lenses in a 24-month period of time.

5. Covered expenses do not include and no benefits are paid for:

(a) Charges for services or supplies covered under any other part of the plan;

(b) Eye examinations for optical lenses;

(c) Frames;

(d) Special procedures, such as orthoptics or vision training and special supplies, such as non-prescription sunglasses or subnormal vision aids.

Part III. Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance-abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. **STAFF MEMBERS ARE ASSURED THAT THE FPR PROGRAMME IS CONDUCTED IN THE STRICTEST CONFIDENCE.** The procedure is as follows:

1. Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll free Aetna number ((800) 445-5299). This call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber himself or herself, the attending physician, a

family member, or any other person acting for the patient to be hospitalized.

2. The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the schedule admission date.

3. The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician. Failure to pre-certify an in-patient admission for mental and nervous and substance-abuse treatment will result in a $400 reduction of the benefit amount paid.

4. An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. <u>In-patient mental and nervous and substance abuse care</u>

1. The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-payment provisions.

2. The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under paragraph 3 below.

3. Coverage for up to 30 days of hospitalization for substance-abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under paragraph 2 above.

C. <u>Out-patient mental and nervous and substance abuse care</u>

1. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric

social worker). The maximum recognized charge per visit for such treatment, $134, is reimbursable at 80 per cent, i.e., $107.20. The annual maximum will be $3,216 (30 visits x $107.20 = $3,216). Under this arrangement, the minimum number of covered visits per year will be 30. Visits beyond this number will be covered until the annual (calendar year) maximum of $3,216 has been reached. Provider fees exceeding the $134-per-visit rate or the $3,216 annual maximum will be borne by the participant. Co-payments made in respect of this benefit do not apply to the $1,000 annual co-payment maximum.

2. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Part IV. Discount prescription drug programme (Aetna Pharmacy Management)

A. The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Walgreens Healthcare Plus, reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Walgreens Healthcare Plus mail order facility.

1. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Walgreens Healthcare Plus mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

2. The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice along with the Aetna card (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-payment of 15 per cent (rather than the normal 20 per cent co-payment) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

3. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through Walgreens Healthcare Plus mail order facility which will charge a fixed $10 co-payment. The Walgreens order form supplied with the Aetna card should be utilized for ordering prescription drugs by mail. A new order form will be sent along with the filled prescription.

4. For residents of the State of New Jersey, the Walgreens Healthcare Plus mail order facility is not available at this time. However, up to a 90-day supply for maintenance prescription drugs can be obtained by presenting the Aetna card at participating pharmacies in New Jersey. The co-payment for 90-day supplies of maintenance drugs will be 15 per cent and never more than $15 per prescription.

5. It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand-name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the Walgreens mail order facility even though it has not been specifically prescribed, Walgreens will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

B. As the Aetna prescription drug programme benefit is being administered separately by Aetna Pharmacy Management, the normal annual deductible under the Aetna plan will NOT be applied to prescription drugs. At the same time, however, prescription drug expenses will NOT count towards meeting the annual co-payment limit of $1,000. Prescription drugs obtained outside the United States or within the United States but NOT through either the Aetna pharmacy network or the Walgreens mail order facility will be reimbursed in the normal manner through the submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the normal annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-payment, which will count towards meeting the annual co-payment limit of $1,000.

Part V. Other provisions

A. Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

B. Unlimited overall lifetime reimbursement benefits.

C. Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, the Aetna claims office should be contacted at (800) 858-5630 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

D. If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

E. Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY AETNA LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

Annex II

BLUE CROSS BLUECHOICE PPO

Plan outline

With effect from 1 July 1996, the WrapAround Plus plan will no longer be offered and will be replaced by Blue Cross BlueChoice, a preferred provider plan very similar to WrapAround Plus. The BlueChoice plan has been under development by Blue Cross for a number of years while WrapAround Plus has been phased out. The BlueChoice plan is, in effect, an updated and expanded version of WrapAround Plus.

The BlueChoice plan, like WrapAround Plus, blends some of the features of a full indemnity (fee-for-service) plan with the advantages of an extensive network of participating providers covering most medical specialties. When treatment is rendered by a preferred (in-network) provider, the only charge to the participant is $10 (except for mental health/substance abuse treatment). On the other hand, the participant may equally be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating (out-of-network) providers will be reimbursed subject to a deductible and 20 per cent co-payment. The deductible and 20 per cent co-payment requirement must be met each calendar year.

While a brief summary of the BlueChoice plan is set out below, the principal differences between the BlueChoice plan and the expiring WrapAround Plus plan are as follows. First, BlueChoice offers a greatly expanded network of physicians and other medical providers in the greater New York metropolitan area compared with WrapAround Plus. Second, the $1 million lifetime limit under the WrapAround Plus programme will not apply in the new BlueChoice programme, which will have no lifetime maximum. The third key feature of the BlueChoice plan is the requirement that all non-emergency hospital admissions be pre-certified through the Blue Cross Utilization Management Programme. Other benefit features of the new plan are described under the heading "Benefits" below.

ALL SUBSCRIBERS TO THE CURRENT BLUE CROSS WRAPAROUND PLUS PLAN WILL BE AUTOMATICALLY ENROLLED AT THE APPROPRIATE LEVEL OF COVERAGE IN THE NEW BLUE CROSS BLUECHOICE PLAN. UNLESS A WRAPAROUND PLUS SUBSCRIBER WISHES TO TAKE THE OPPORTUNITY OF THE ENROLMENT CAMPAIGN TO SWITCH TO AETNA, HIP OR KAISER, NO ENROLMENT ACTION IS REQUIRED. OF COURSE, IF A STAFF MEMBER CURRENTLY ENROLLED IN WRAPAROUND PLUS WISHES TO ADD A DEPENDANT TO HIS OR HER COVERAGE UNDER THE BLUECHOICE PLAN AFTER 1 JULY 1996, THEN APPROPRIATE APPLICATION MUST BE MADE DURING THE ENROLMENT CAMPAIGN PERIOD.

Premiums

The monthly premium for the Blue Cross BlueChoice plan will be 9.7 per cent higher than the current level of premiums pertaining to the expiring WrapAround Plus plan. The new premiums and percentages of salary contribution are shown on page 2 of the present circular.

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Benefits

Apart from unlimited lifetime benefits and the greatly expanded provider network referred to above, the new BlueChoice scheme offers several additional benefit enhancements, as follows:

A. A routine annual physical examination. This is an in-network benefit only.

B. An expanded number of out-patient visits for mental health and alcoholism/substance abuse treatment, for a combined total of 60 in-network or out-of-network visits per annum. All in-network mental health and substance abuse treatment (in-patient or out-patient) must be pre-approved under the Blue Cross Behavioral Health Care Management Programme (BHCMP). Out-of-network mental health and alcoholism/substance abuse out-patient treatment does not require pre-certification. In-network visits are subject of a $25 co-payment per visit while out-of-network visits are subject to deductible and 50 per cent co-insurance based on reasonable and customary charges.

C. A facility known as "Personal Health Adviser". This facility is a toll-free, 24-hour health information service, including access to registered nurses and an audio health library comprising over 400 health care topics.

D. An improved vision care benefit.

The special toll-free telephone numbers to call in order to pre-certify a hospital admission or to receive mental health and alcoholism/substance abuse treatment may be found in annex VIII to the present circular.

Preferred (in-network) providers

A network of physicians covering New York City and the New York metropolitan area participate in the BlueChoice plan and accept as payment a fee schedule arranged with Blue Cross. No deductible has to be met, but instead, the participant pays a $10 co-payment for each visit ($25 for mental health). If, however, a participating physician refers a patient to, or engages the services of, another provider who is non-participating, the deductible and 20 per cent co-payment will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider (50 per cent co-payment for mental health visits). A number of diagnostic laboratories are participating providers under the BlueChoice plan. When any laboratory tests are required, it is important that the physician be told to direct the tests to a participating laboratory, if possible. If this is done, the cost of the laboratory test will be paid in full and will not be subject to the normal deductible and co-payment.

Out-of-network provider utilization

Should the participant choose to be attended to by a non-participating (out-of-network) provider or be referred by an in-network physician to an out-of-network provider, BlueChoice will pay 80 per cent of the reasonable and customary charge after the participant has met a $150 deductible per individual/$450 per family. After $900 of unreimbursed reasonable and customary medical expenses have been paid by the participant in a given year, further reasonable and customary expenses will be reimbursed in full (100 per cent in lieu of 80 per cent).

BlueChoice medical network directory and benefits handbook

Blue Cross has substantially expanded the number of participating providers under all specialties in the New York metropolitan area. While this expansion greatly increases the choice of providers available to participants in the plan, the list itself, over 500 pages, is too voluminous to be reproduced here.

Blue Cross has prepared a comprehensive handbook describing the benefits under the plan and providing useful general and administrative information.

ARRANGEMENTS HAVE BEEN MADE WITH BLUE CROSS FOR BOTH THE MEDICAL NETWORK DIRECTORY AS WELL AS THE BLUECHOICE BENEFITS HANDBOOK TO BE MAILED TO PARTICIPANTS AT THEIR PLACE OF RESIDENCE. EACH PARTICIPANT IN THE BLUECHOICE PLAN WILL RECEIVE NEW IDENTIFICATION CARDS (A BLUECHOICE IDENTIFICATION CARD AND A NEW PRESCRIPTION DRUG PLAN IDENTIFICATION CARD). ENCLOSED IN THE ENVELOPE CONTAINING THE NEW BLUECHOICE IDENTIFICATION CARD WILL BE A PRE-ADDRESSED POSTCARD FOR RETURN TO BLUE CROSS TO BE COMPLETED WITH THE NAME AND HOME ADDRESS OF EACH SUBSCRIBER. ONLY BY RETURNING THE POSTCARD TO BLUE CROSS WILL BLUECHOICE SUBSCRIBERS RECEIVE THE BLUECHOICE DIRECTORY AND BENEFITS HANDBOOK, AS COPIES OF THE DIRECTORY AND HANDBOOK WILL NOT BE HELD IN STOCK AT THE UNITED NATIONS.

Benefit and claim questions

Certain expenses are not covered under the BlueChoice plan. These comprise expenses for services or supplies not deemed by Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Blue Cross as reimbursable under the plan, Blue Cross should be contacted at (800) 377-5156 prior to commencement of treatment. In addition, the Blue Cross policy contract document is on file in the offices of the Insurance Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

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Blue Cross BlueChoice Plan Benefits Summary

Part I. BlueChoice In-Network and Out-Network Hospitalization/Major Medical Benefits

LIFETIME MAXIMUM	Unlimited	Unlimited
HOSPITAL BENEFITS	**Member Pays**	
INPATIENT* (Except Mental Health) Unlimited days-semiprivate room and board	$0	
INPATIENT PHYSICAL THERAPY, PHYSICAL MEDICINE OR REHABILITATION* (45 INPATIENT DAYS PER CALENDAR YEAR)	$0	
MENTAL HEALTH ** Up to 90 days per calendar year	$0	
ALCOHOL/SUBSTANCE ABUSE** Up to 7 days detox, up to 30 days rehab per calendar year	$0	
OUTPATIENT Ambulatory surgery*, surgery*, pre-surgical testing, chemotherapy & radiation therapy, mammography & cervical cancer screening	$0	
EMERGENCY ROOM/FACILITY Initial visit (Accidental injury or sudden & serious medical condition)	$35 copay (waived if admitted within 24 hours)	
OTHER FACILITY BENEFITS	**Member Pays**	
ALCOHOL/SUBSTANCE ABUSE** Up to 60 outpatient visits which include 20 family counseling visits per calendar year	$0	
HOME HEALTH CARE* Up to 200 visits per calendar year	$0	
OUTPATIENT KIDNEY DIALYSIS	$0	
HOSPICE Up to 210 days per lifetime	$0	
SKILLED NURSING FACILITY* Up to 365 days per calendar year	$0	

* Precertification by our Utilization Management Program (UMP) is required.
** Behavioral Health Care Management Program (BHCMP) must pre-approve all Mental Health and Alcohol/Substance Abuse services - this does not apply to out-of- network outpatient psychiatric visits.

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BENEFITS	IN-NETWORK	OUT-OF-NETWORK
PROGRAM BENEFITS	IN-NETWORK	OUT-OF-NETWORK
COST SHARING	MEMBER PAYS	MEMBER PAYS
DEDUCTIBLE	NOT APPLICABLE	$150/$450 INDIVIDUAL/FAMILY
COINSURANCE	NOT APPLICABLE	20%
COINSURANCE MAXIMUM	NOT APPLICABLE	$900/INDIVIDUAL
MEDICAL BENEFITS	Member Pays	Member Pays
HOME/OFFICE VISITS Physician and Specialist	$10 copay	Deductible and Coinsurance
ANNUAL PHYSICAL EXAM	$10 copay	Not Covered
WELL CHILD CARE (Up to Age 19) (Including necessary immunizations)	$0	Deductible and Coinsurance
WELL WOMAN CARE	$10 copay	Deductible and Coinsurance
INPATIENT VISITS	$0	Deductible and Coinsurance
DIAGNOSTIC SCREENING & MAMMOGRAPHY	$0	Deductible and Coinsurance
MATERNITY	$0	Deductible and Coinsurance
SURGERY	$0	Deductible and Coinsurance
SURGICAL ASSISTANT	$0	Deductible and Coinsurance
ANESTHESIOLOGY	$0	Deductible and Coinsurance
LAB & X-RAY	$0	Deductible and Coinsurance
MENTAL HEALTH** • Up to 60 outpatient visits in office or facility • Up to 90 inpatient visits per calendar year	$25 copay per visit $0	Deductible and 50% Coinsurance Deductible and 50% Coinsurance
ALLERGY TESTING & TREATMENT	$10 copay (waived for treatments)	Deductible and Coinsurance
SECOND SURGICAL OPINION	$0	Deductible and Coinsurance
PHYSICAL THERAPY • 30 visits combined in home, office, outpatient facility • 45 days inpatient	$10 copay (home or office); $0 in facility	Deductible and Coinsurance

* Precertification by our Utilization Management Program (UMP) is required.
**Behavioral Health Care Management Program (BHCMP) must pre-approve all Mental Health and Alcohol/Substance Abuse services - this does not apply to out-of-network outpatient psychiatric visits.

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OTHER THERAPIES (occupational, speech, hearing, vision) combined 30 visits in home, office, outpatient facility	$10 copay (home or office); $0 in facility	Deductible and Coinsurance
PRIVATE DUTY NURSING (In home only) Up to $5,000 per year; $10,000 lifetime maximum	Not Applicable	$0, Not Subject to Deductible and Coinsurance
MEDICAL SUPPLIES	Not Applicable	$0, Not Subject to Deductible and Coinsurance
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, & ORTHOTICS	$0	Deductible and Coinsurance
AMBULANCE	Not Applicable	$0, Not Subject to Deductible and Coinsurance
CHIROPRACTIC CARE	30 visits at $30 per visit	
PRESCRIPTION DRUG CARD PROGRAM	15% copay up to a maximum of $15 per perscription; Mail order with $10 copay	15% coinsurance (claim must be filed for reimbursement)
VISION CARE	One exam each 24 months with $10 copay; $10 copay for frames, $35 allowance for non-plan eyewear	Not Covered
HEARING AID	Not Applicable	One exam every three years; (limit $100); one hearing aid per ear (limit $600) every two years

* Precertification by our Utilization Management Program (UMP) is required.
**Behavioral Health Care Management Program (BHCMP) must pre-approve all Mental Health and Alcohol/Substance Abuse services - this does not apply to out-of-network outpatient psychiatric visits.

Note: No Precertification for hospital admission (UMP) or Mental Health and Substance abuse services (BHCMP) is required when using providers outside the United States.

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Part II. Discount prescription drug programme (Empire Pharmacy Management)

1. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network is provided by Empire Pharmacy Management through Diversified Pharmaceutical Services as well as a mail order facility through Caremark, Inc. Prior to 1 July 1996, each subscriber will receive at their office location a new prescription drug identification card (if already enrolled in the Blue Cross BlueChoice plan) indicating enrolment in the Empire Pharmacy Management programme. The card will come in an envelope which will also contain an application for the purpose of filing mail order claims with Caremark, Inc.

2. Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the Caremark mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through Caremark will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

3. The procedure under which prescription drugs is reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice ALONG WITH THE EMPIRE PHARMACY MANAGEMENT CARD (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-payment of 15 per cent (rather than the normal 20 per cent co-payment) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

4. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the Caremark, Inc. mail order facility, which will charge a fixed $10 co-payment per prescription. The Caremark claim form supplied with the Empire Pharmacy Management card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription.

5. It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request even though the physician has

not specified a brand-name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the Caremark mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

6. As the Blue Cross BlueChoice prescription drug programme is being administered separately by Empire Pharmacy Management, the normal annual deductible under the BlueChoice plan will NOT be applied to prescription drugs. At the same time, however, prescription drug co-payments will NOT count towards meeting the annual co-insurance limit of $900. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management Diversified Pharmaceutical Services' participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Route 4140
Box 169052
Duluth, MN 55816-9052

The special claim form to be utilized for this purpose is available in the offices of the Insurance Section, room S-2765. Claims submitted to the claims office will not be subject to the annual deductible. However, a 15 per cent co-payment will be assessed on the charges submitted and the $15 limit for each prescription will NOT apply. In addition, the 15 per cent co-payment will not count towards meeting the annual co-payment limit of $900.

Part III. Other provisions

1. If Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstance require more time, Blue Cross can extend the review period up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross and Blue Shield
P.O. Box 4606
New York, NY 10163-4606
Attention: Group Accounts

2. Subscribers should note that claims for reimbursement must be submitted to Blue Cross no later than two years from the date on which the medical expense was incurred. CLAIMS RECEIVED BY BLUE CROSS LATER THAN TWO YEARS AFTER THE DATE ON WHICH THE EXPENSE WAS INCURRED WILL NOT BE ELIGIBLE FOR REIMBURSEMENT.

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Annex III

HEALTH INSURANCE PLAN OF GREATER NEW YORK/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The HIP/HMO plan follows the concept of total prepaid group practice hospital and medical care, i.e., there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians or any physician in a covered emergency. HIP/HMO participants may select a physician at a HIP medical centre or from a new listing of neighbourhood affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. Specialty care, however, will continue to be given in a HIP medical centre based upon the referral of the selected affiliated physician. To select a neighborhood affiliated physician, the HIP participant should call HIP at (800) HIP-TALK. Additional information regarding this expansion of HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants.

Premium

The monthly premium for the HIP/HMO plan will decrease by 3.4 per cent compared with present rates for the renewal period commencing 1 July 1996. The new premiums and percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Benefits under the HIP/HMO plan will remain unchanged in the renewal period.

HIP/HMO benefits summary

Type of benefit	HIP/HMO coverage
Hospital services	Covered in full when authorized by HIP/HMO physician
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency

Type of benefit	HIP/HMO coverage
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/ health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services:	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems. Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded
Alcoholism and substance abuse:	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance-abuse treatment facility

Type of benefit	HIP/HMO coverage
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services
Emergency services:	
In area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service
Out of area	Hospital service: In-patient - covered in full; Out-patient - covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury. Doctor services - HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	$5 co-payment for prescription drugs, but not appliances, when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency
Grievance procedure	Refer to member handbook sent to subscribers

Annex IV

KAISER FOUNDATION HEALTH PLAN OF THE NORTHEAST/HEALTH MAINTENANCE ORGANIZATION

Plan outline

The Kaiser Foundation Health Plan is an HMO, providing all medical-related services at any one of four health centre locations, accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut as well as hospitalization when authorized by a Kaiser physician. Participants will also have the option of continuing to receive care at a Kaiser medical centre or from any of more than 90 physicians associated with the Katonah Medical Associates or Physician's Choice, two multi-specialty medical groups serving Westchester and Connecticut, respectively. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services, no deductibles to cover and no insurance forms to complete. The plan coverage emphasizes early detection of medical problems before they become major illnesses.

Premium

The monthly premium for the Kaiser/HMO plan will increase by approximately half a per cent compared with present rates for the renewal period commencing 1 July 1996. The new premiums and percentages of salary contribution are shown on page 2 of the present circular.

Benefits

Benefits under the Kaiser/HMO plan will remain unchanged in the renewal period.

Kaiser/HMO benefits summary

Type of benefit	Kaiser/HMO coverage
Hospital services	Covered in full when authorized by a Kaiser physician
In-hospital rehabilitation	60 days of in-patient rehabilitation care per condition provided in a hospital or skilled nursing facility
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician
Private duty nursing	Covered in full when considered medically necessary

Type of benefit	Kaiser/HMO coverage
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician
Visits to physicians' office/health centre centre	Covered in full at any Kaiser medical nationwide or if rendered by or referred by a Kaiser physician
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Prenatal, postnatal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when rendered or authorized by a Kaiser physician
Alcoholism treatment:	
In-patient	Covered in full for detoxification only
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism
Mental health services:	
In-patient	Covered in full for 30 days per contract year
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1-10 per contract year. Visits 11-20 are covered subject to a 25 per cent co-payment of the Kaiser fee-for-service rate. Visits 21-30 are covered at 50 per cent of the Kaiser fee-for-service rate

Type of benefit	Kaiser/HMO coverage
Emergency services:	
$25 co-payment	A $25 co-payment will be assessed for emergency care services. Immediate notification to Kaiser required if admitted to a hospital (or within a reasonable period of time if incapacitated). Out-patient emergency care requires 48-hour notification to Kaiser, i.e., within 48 hours after the care is received
In area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment
Out of area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours
Prescription drugs and medical appliances	$3 co-payment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement
Grievance procedure	Refer to member handbook sent to subscribers

Annex V

GROUP HEALTH INCORPORATED (PREFERRED) DENTAL PLAN

Plan outline

The GHI "Preferred" Dental plan is a defined benefit scheme, i.e., benefits are paid in accordance with an established schedule of allowances for a wide range of dental procedures. While the schedule of benefits available under the GHI "Preferred" Dental plan may be utilized to offset the costs of dental services provided by independent (fee-for-service) practitioners, staff members are encouraged to make maximum use of the dental practitioners who participate in the GHI Dental plan. In most cases, GHI participating (or network) providers accept the "Preferred" schedule of allowances as payment in full for services rendered. The plan involves no deductible and no co-payment on the part of the subscriber. Thus, treatment by a participating GHI provider will, in most cases, involve no financial outlay by the subscriber.

Premium

The claims experience relating to the GHI Dental plan was somewhat adverse last year owing to heavy utilization of plan benefits. As a result, the monthly premium will increase by 11.6 per cent compared with present rates for the renewal period commencing 1 July 1996. The new premiums and percentages of salary contribution are shown on page 2 of the present circular.

Benefits

The benefits under the GHI "Preferred" Dental plan will remain unchanged for the renewal period.

GHI directory of participating providers

A complete directory listing GHI participating dental providers in the greater New York metropolitan area is available in the offices of the Insurance Section, room S-2765. Copies of the updated directory will be available from 1 July 1996.

GHI dental benefits summary

	Maximum allowance $
EXAMINATIONS	
Periodic	15
Initial	20
Emergency	15

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	Maximum allowance $
PROPHYLAXES (cleaning)	
Two per calendar year	
Under 12 years	20
12 years and over	30
ORAL SURGERY - EXTRACTIONS	
Impaction - Complete bone	150
Soft tissue	100
Partial bone	125
Extraction - Difficult	50
Routine	30
RESTORATIONS (FILLINGS)	
Amalgam - One surface	30
Two surfaces	40
Three surfaces	50
Reinforcement pin, maximum one per tooth	15
Synthetic porcelain composite - Per filling	30
Two fillings	45
Maximum per tooth	50
Molar, open reduction, depressed compound	300
Tooth reimplantation caused by trauma due to forces outside the mouth	50
Temporo-mandibular joint (TMJ), closed reduction	75
Acrylic/three fillings, maximum per tooth	N/A
Composite fillings	35
Two fillings	45
Three fillings, maximum per tooth	50
Temporary fillings	None
ORAL SURGERY - OTHER	
Maxilla, open reduction - Simple	300
Compound	450
Mandible, closed reduction - Simple	350
Compound	350
Mandible, open reduction, compound	450
Molar, closed reduction, simple	100
TMJ, closed reduction with wiring	150
Incision and drainage of periodontal abcess	25
Cyst removal	75
Incision and drainage of abscess	35

	Maximum allowance $
Biopsy and examination of oral tissue	35
Biopsy report	20
Closure of oral antral fistula	100
Removal - Labial frenum	100
Lingual frenum	100
Alveolectomy, upper jaw with extractions - Per tooth	10
Maximum upper	100
Alveolectomy, lower jaw with extractions - Per tooth	10
Maximum lower	100
Alveolectomy without extractions, per quadrant - Upper jaw	100
Lower jaw	100
ORTHODONTICS	
(Benefits are available only to eligible children to the end of the calendar year in which they reach age 19.)	
Removal - Preliminary acrylic	75
Metal appliance	75
Fixed or cemented - Acrylic	75
Metal	75
Diagnosis, construction and insertion of orthodontic appliance	300
Active orthodontic treatment (next 20 months)	67
Lifetime maximum allowance	1 340
Six months passive treatment	36
Maximum allowance (18 months)	108
EMERGENCY TREATMENT	
Emergency visit for relief of pain	15
PERIODONTICS	
Periodontal treatment	40
Maximum allowance each calendar year	200
Gingivectomy, five-teeth area	135
Osseous surgery, per quadrant	250
PROSTHETIC SERVICES	
Immediate full denture - Upper	400
Lower	400

	Maximum allowance $
Permanent full denture - Upper	400
Lower	400
Acrylic partial denture, 2 + clasps and rests - Upper	285
Lower	285
Cast partial denture, 2 + clasps and attachment - Upper	425
Lower	425
Cast partial denture, 2 + clasps, no attachment - Upper	425
Lower	425
Unilateral partial (Nesbitt) - One tooth	145
Two teeth	160
Three teeth	160
Add tooth to partial denture - First tooth	50
Additional teeth, per tooth	20
Adding new clasp to existing partial	54
Obturator, not including denture	200
Rebase or reline (R/R) lab processed	
Full denture - Upper	130
Lower	130
Partial denture - Upper	130
Lower	130
Denture, chairside - Full upper	90
Full lower	90
Partial upper	75
Partial lower	75
Duplicating partial - Upper jaw	160
Lower jaw	160
Pontic - Cast metal or acrylic	175
Porcelain fused to metal	200
Porcelain veneer abutment crown	375
Acrylic veneer abutment crown	325
Full cast abutment crown in 3 + unit bridge	300
3/4 cast abutment crown in 3 + unit bridge	215
Maryland bridge retainer	135
Inlay - Two-surface metallic abutment in 3 + unit bridge	150
Three-surface metallic abutment	200
Metal post with or without coping	95
Crown - 3/4 cast	215
Full cast	300
Full cast with acrylic veneer	325
Full cast with porcelain veneer	375
Inlay - Two surfaces - metallic	125
Three surfaces - metallic	150
Porcelain jacket crown	225
Acrylic/vinyl jacket crown, lab-processed	125
Crown - Steel shell	60

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	Maximum allowance $
PROSTHETIC REPAIR	
Repair broken denture with or without broken teeth	45
Replace broken teeth in broken denture, per tooth	28
Repair broken teeth in denture not requiring other repairs	
First tooth	50
Each additional tooth	25
New clasp/replacing broken clasp	75
Reattach undamaged clasp	40
Replacing facing on pontic or crown	40
Recementing fixed bridge - single inlay, crown or facing	20
Two or more abutments	30
Maximum repairs per family member per calendar year	110
ENDODONTICS	
Root canal therapy (RCT) - One canal filled	175
Two canals filled	225
Three canals filled	275
Pulpotomy	50
Apicoectomy, single procedure	140
Apicoectomy, including RCT and/or root-end amalgam	245
Each additional canal	50
MISCELLANEOUS	
Fluoride treatment - Stannous	15
Anaesthesia in-hospital, each 15 minutes of anaesthesia	24
Consultation with dental specialist	35
Professional visit to bedside	20
Mouth guard for athletic purposes - removable acrylic	50
Space maintainer - Fixed band type, lingualar palatal arch	100
Fixed, unilateral band type	75
RADIOLOGY	
PA X-ray - Initial	3
Each additional	3
Full mouth series, maximum one every three years	30
Intra-oral films, occlusal view for endentulous jaws, maxillary or mandibular, single film, two every three years	10
Bite-wing X-ray - Initial	6
Each additional film	6
Maximum four each calendar year	24

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	Maximum allowance $
Antero-posterior head and jaw, single film	25
Lateral X-ray, head and jaw, single film	25
Temporo-mandibular joint (TMJ), single film	25
Cephalometric X-ray	25
Panoramic, one series every three years	30

PRE-DETERMINATION AMOUNT

If a course of treatment can reasonably be expected to involve covered dental expenses of $200 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with GHI before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed.

ANNUAL MAXIMUM

THERE IS A CALENDAR YEAR BENEFIT MAXIMUM OF $2,000.

For a fuller description of the dental procedures covered under the GHI Preferred Plan, including a summary of the principal limitations and exclusions, participants should consult the Preferred Plan brochure. Copies of the brochure are available at the offices of the Insurance Section, room S-2765.

Grievance procedure

If a subscriber disagrees with the disposition of a claim by GHI, a review may be requested. Such request must be made in writing to GHI (Attention: Claims Appeals) within 60 days of notification. The subscriber's GHI certificate number and the claim number concerned, as well as any pertinent information regarding the disputed claim, should be included in the request for review. Upon receipt of the request for review, the claim will then be reconsidered, taking into account such additional information as may have been provided by the subscriber. Upon completion of this review, the subscriber will receive written notification of the decision, explaining the upholding or modification of the original disposition of the claim.

Annex VI

WORLD ACCESS

World Access (formerly known as Access America) is a facility available to Aetna and BlueChoice subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and BlueChoice set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of EMERGENCY foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Blue Cross BlueChoice identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna for reimbursement or Blue Cross, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 - (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 - collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065. In addition, you are reminded that your Aetna and Blue Cross BlueChoice subscriber identification number is:

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Annex VII

AETNA AND BLUE CROSS/WRAPAROUND PLUS PLANS
LIST OF PARTICIPATING PHARMACIES

Set out below are lists of the major participating chain pharmacies under the Aetna and Blue Cross BlueChoice pharmacy management programmes. The full Aetna and Blue Cross directories of participating pharmacies are far too large to reproduce in this annex and include, in addition to major chains, the names and addresses of many thousands of individual participating pharmacies. These directories are available for consultation and photocopying, as necessary, at the offices of the United Nations Insurance Section; the Division of Personnel, UNDP; and the Office of Personnel, UNICEF. In addition, if a participating pharmacy is needed while traveling, referral information is available from Aetna ((800) 858-5630) and Blue Cross ((800) 233-8065).

Aetna Participating Chain Pharmacies

New York

AARP Pharmacy Service
A & P Pharmacy
Brooks Drug
Caldor Phcy
Costco Pharmacy
CVS
Drug Mart
Drug World
Duane Reade Corporation
Edwards Pharmacy
Fay's
Finast Pharmacy
Freddy's
Genovese Drug Store
Grand Union Phcy
Great American Drug
K Mart Pharmacy
King Kullen Pharmacy
Kinney Drugs
Leroy Pharmacy
The Medicine Shoppe
Pathmark Pharmacy
Peterson Drug Company
Phar-Mor
Pharmhouse
Price Chopper Pharmacy
Revco
Rite Aid
Rockbottom Pharmacy
Shop 'N Save Phcy
Shop Rite Pharmacy
The RX Place
The Stop & Shop Supermarket
Thrift Drug
Tops Pharmacy
Vix Pharmacy
Waldbaums Pharmacy
Walgreens
Wal-Mart
Wegmans Pharmacy
Weis Pharmacy
Woolworth Pharmacy

New Jersey

Acme Pharmacy
A & P Pharmacy
Brooks Drug
Caldor Phcy
Clover Pharmacy
Costco Pharmacy
CRX Pharmacy
CVS
Drug Fair
Drug World
Duane Reade Corporation
Eckards Drugs
Food Town Phcy
Foodmax Pharmacy
Genovese Drug Store
Grand Union Phcy
Happy Harry's
K Mart Pharmacy
The Medicine Shoppe
Pathmark Pharmacy
Phar-Mor
Pharmhouse
Quick Check
Revco
Rite Aid
RXD Pharmacy
Sav-On
Shop Rite Pharmacy
Super X Drug Store
The RX Place
Thrift Drug
Thrift RX
Waldbaums Pharmacy
Walgreens
Wal-Mart
Woolworth Pharmacy

Connecticut

AARP Pharmacy Service
A & P Pharmacy
Arrow Prescription Center
Arthur Drug Stores
Brooks Drug
Caldor Phcy
Costco Pharmacy
CVS
Douglas Drug
Edwards Pharmacy
F & M Distributers
Genovese Drug Store
Grand Union Phcy
K Mart Pharmacy
The Medicine Shoppe
NPSC/EPIC
Pathmark Pharmacy
Purity Pharmacy
Rite Aid
Shop Rite Pharmacy
Super X Drug Store
The RX Place
The Stop & Shop Supermarket
Waldbaums Pharmacy
Walgreens
Wal-Mart
Woolworth Pharmacy

Blue Cross BlueChoice Participating Chain Pharmacies

A & P
Arrow
Brooks
Caldor
CVS
Drug Fair
Duane Reade
Fay's
Genovese
Grand Union
K-Mart
Kings
King Kullen
Kinney
McKay
Medicine Shoppe Internet
Pathmark
Quick Chek
Revco
Rite Aid
Rockbottom
R X D
The Rx Place
Shop Rite
Stop and Shop
Thrift Drug
Waldbaum's
Walgreen's
Wal-Mart
Woolworth

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Annex VIII

INSURANCE CARRIER ADDRESSES AND TELEPHONE NUMBERS FOR CLAIMS AND BENEFIT INQUIRIES

I. AETNA MAJOR MEDICAL PLAN (medical and out-of-network pharmacy claims)	Aetna Life Insurance Company Unit 73 3541 Winchester Road Allentown, PA 18195-0501
Tel.: (800) 858-5630	For benefit and claim questions For participating pharmacy referral
(800) 445-5299	Focused Psychiatric Review (FPR)
Walgreen's Customer Service Tel.: (800) 999-2655	Maintenance drug mail order company
II. BLUE CROSS BLUECHOICE PLAN	Empire Blue Cross 622 Third Avenue New York, NY 10017
BlueChoice PPO Member Services Tel.: (800) 377-5156	For questions about benefits, claims or membership
Utilization Management Program Tel.: (800) 982-8089	For prior approval of hospital admissions, elective surgery, home care, skilled nursing facility benefits and referrals for second opinions
Behavioral Health Care Management Program Tel.: (800) 626-3643	For prior approval of mental health/ substance abuse care
Caremark, Inc. Tel.: (800) 831-4440	Maintenance drug mail order company
Diversified Pharmaceutical Services Tel.: (800) 233-8065	For information about prescription drug card and mail-order prescription drug programs; to find a network pharmacy
III. HIP/HMO Tel.: (800) HIP-TALK ((800) 447-8255)	HIP Member Services Department 7 West 34th Street New York, NY 10001
IV. KAISER/HMO Tel.: (914) 682-6500	Kaiser Foundation Health Plan 210 Westchester Avenue White Plains, NY 10604
V. GHI DENTAL PLAN Tel.: (212) 501-4443 (for claim questions and participating provider referrals)	Group Health Incorporated (GHI) P.O. Box 1701 New York, NY 10023 Attention: Dental Correspondence Unit

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